Ministry of Community Development, Mother and Child Health Behaviour Change Programming Capacity Assessment Index Report

February 2014

Contents

1. Introduction

The main objective of the United States Agency for International Development–funded Communications Support for Health (CSH) project is to strengthen the capacity of the Government of the Republic of Zambia's (GRZ) Ministry of Community Development, Mother and Child Health (MCDMCH), National Malaria Control Centre (NMCC), and National HIV/AIDS/STI/TB Council (NAC) to develop and implement evidence-based behaviour change communication (BCC) interventions. To help measure progress towards this objective, CSH administers an annual assessment of the capacity of MCDMCH, NMCC, and NAC to plan, implement, and manage BCC interventions.

1.1. Overview of the Capacity Assessment Index

The Behaviour Change Programming (BCP) Capacity Assessment Index was developed by the CSH project. It is a tool for assessing the capacity of an institution to plan, implement, monitor, and evaluate BCC interventions and programmes. The index provides an overall score (out of 100) and summary scores for each of the following specific capacity areas: BCC planning and design, programme implementation, and monitoring and evaluation (M&E). The results from the assessment are tracked within CSH's Performance Monitoring and Evaluation Plan. The assessment is administered annually.

1.2. Objectives of the Assessment

1.2.1. Main Objective

The main objective of the capacity assessment is to identify gaps in GRZ's capacity to design, implement, and monitor and evaluate behaviour change interventions, with the aim of strengthening capacity in the areas that are identified as needing improvement.

1.2.2. Specific Objectives

Specifically, the objectives of the assessment are to

- Identify gaps in planning, designing, implementing, and monitoring and evaluating BCC interventions; and
- Inform the design of CSH's capacity-building initiatives for GRZ, such as providing further trainings in BCC and systems development.

1.3. Methodology

The BCP Capacity Assessment Index tool was administered in a workshop setting to staff within the Health Promotion Unit of MCDMCH by the CSH M&E Unit. Four staff members from the Health Promotion Unit, the unit responsible for the design, implementation, and management of BCC programmes, participated in the assessment. Two members of the CSH M&E Unit facilitated the workshop in order to probe for more details, review responses, and gain consensus on the scores awarded. The tool was administered to the staff from the target unit of MCDMCH to ensure that responses represent the views of MCDMCH and not those of the individual participants. This approach was perceived to be an effective way of obtaining sufficient information from the participants. The assessment tool was projected on a wall using a liquid-crystal-display projector so that all participants and the assessor, Collins Muntanga (Research, Monitoring and Evaluation Advisor), could read through the assessment items together. During

the discussion, another CSH staff member asked probing questions as well as recorded notes and scores.

Although the assessment and timelines are linearly indicated, the actual process was iterative and mainly driven by ideas as they developed from one stage to another. In addition, the process was accompanied by the very useful documentation verification.

The assessment was administered in a workshop setting at MCDMCH on 7 February 2014. Even though the assessment was conducted within MCDMCH premises, the activity was free of disruptions. The assessment lasted approximately three hours.

The baseline Capacity Assessment Index tool for the Government Health Promotion Unit was administered in 2012 when the unit was under the Ministry of Health (MOH). However, in 2013, the GRZ undertook realignment of its ministries. In this undertaking, the Health Promotion Unit, which was then under MOH, was moved to be within the new ministry, MCDMCH. Staff who worked in this unit when it was still under MOH were also moved to the new ministry (MCDMCH). Therefore, the realignment of ministries did not result in any notable staffing issues.

1.4. Key Assessment Domains

There are 10 key capacity domains in the capacity assessment, grouped within three main sections:

Section 1: BCC Planning and Design
1.1. Health problem definition and situation assessment
1.2. Conduct of behavioural analysis
1.3. Programme definition and communication strategy development
1.4. Detailed communication planning
1.5. Establishment of strategic partnerships

Section 2: BCC Programme Implementation
2.1. Implementation of communication strategies
2.2. Staff capacity
2.3. Supervision and quality of BCC intervention delivery

Section 3: BCC Monitoring and Evaluation
3.1. M&E frameworks and systems
3.2. Data use

2. Findings

An overview of the scores for each of the three main sections (BCC Planning and Design, BCC Programme Implementation, and BCC Monitoring and Evaluation), as well as the subsections (10 domains), is provided in Table 1.

The results from 2014 capacity assessment show a notable improvement in the capacity of the Health Promotion Unit to plan, implement, and manage BCC interventions. The overall Capacity Assessment Index rose from 53.6 percent in 2012 to 59.14 percent in 2014. In terms of BCC programme design, the average Capacity Assessment Index rose from 63.2 percent in 2012 to

67.92 percent in 2014, while the score for the BCC programme implementation section rose from 66.3 percent in 2012 to 78 percent in 2014. However, the BCC programme monitoring and evaluation section did not show improvement, with the average score remaining stagnant at 31.5 percent for both 2012 and 2014. Table 1 below tabulates the assessment results for both 2012 and 2014 in detail.

Table 1: BCC Capacity Assessment Scores for MCDMCH

Section No.	Section	Average Score (%) 2012	Average Score (%) 2014
1	**BCC Planning and Design**	**63.2**	**67.92**
1.1	Health problem definition and situation assessment	**63**	**62.5**
1.2	Conduct of behavioural analysis	**42**	**75**
1.3	Programme definition and communication strategy development	**81**	**93.8**
1.4	Detailed communication planning	**67**	**58.3**
1.5	Establishment of strategic partnerships	**63**	**50**
2	**BCC Programme Implementation**	**66.3**	**78**
2.1	Implementation of communication strategies	**61**	**96**
2.2	Staff capacity	**75**	**75**
2.3	Supervision and quality of BCC intervention delivery	**63**	**63**
3	**BCC Monitoring and Evaluation**	**31.5**	**31.5**
3.1	M&E frameworks and systems	**25**	**25**
3.2	Data use	**38**	**38**
Overall Score		**53.6**	**59.14**

The key findings from the assessment were as follows:

- The realignment of the Health Promotion Unit from MOH to MCDMCH, which took place after the baseline, stalled the implementation of some capacity-building efforts based on recommendations from the 2012 exercise, as health promotion staff needed considerable time to fit in and stabilise at MCDMCH. These stalled efforts included additional training for staff, quality control of programme implementation, and BCC M&E systems.
- The capacity of the Health Promotion Unit to plan and design BCC interventions has experienced substantial growth.
    - Most notably, the unit has enhanced its abilities to conduct behavioural analysis using existing research and to develop detailed BCC programmes where both the primary and the secondary audiences in their various settings, as well as their needs, are identified in order to promote implementation. This analysis had been reported as being done at the programme planning stage. However, MCDMCH demonstrated overreliance on existing research information, which presented

limitations, since information gaps may exist in secondary data. This overreliance on secondary or existing data was attributed to financial and time limitations.

  - Capacity in defining the health problem and conducting a situational assessment remained at the same level, exhibiting inconsistencies in if and when this process was done, partially due to a lack of resources.
  - The unit illustrated a decrease in capacity in developing detailed communication plans with clear links to indicators. Communication activities are not monitored, as a system to do so does not exist. The Health Management Information System (HMIS) has no health promotion indicators. The capacity in establishing partnerships also experienced a decrease. Stakeholder engagement is not yet at the level that the unit wants to see, and the unit perceives that other units, such as Maternal and Child Health and Voluntary Male Medical Circumcision are doing better in terms of stakeholder engagement. The unit called for the development of the Health Promotion Strategic Plan in order to enhance stakeholder coordination. Established partnerships appear to have been delayed due to a lack of knowledge about the work of partners and agreements to collaborate with the unit.

- The Health Promotion Unit has also demonstrated a significant increase of capacity in BCC programme implementation.
  - This increase is largely due to the implementation of communication strategies to use multiple communication channels to deliver BCC messages and frequent pretesting of BCC products. The unit also noted submitting its products to the Health Promotion Technical Working Group for review.
  - The capacity of staff and supervision of BCC intervention delivery remained at the same level as in 2012, despite the upheavals due to the realignment. The unit reported that many of the staff are undergoing formal training as part of staff development and the need exists for additional trainings for new staff at district and provincial levels. Checklists for quality control of the implementation of interventions are available, but they need revision following the realignment. Supervisory visits to observe the implementation of interventions are also limited. The unit felt that more could be done if more funds were allocated.
- The capacity of the unit to monitor and evaluate BCC interventions remained low. An M&E plan for the Health Promotion Unit does not exist; neither does an M&E plan specifically for BCC interventions/campaigns. No system is in place to generate M&E data, which means that data cannot be used for programme improvement.

3. Challenges

No major challenges were experienced in conducting the capacity assessment even though the assessment was conducted within MCDMCH premises. MCDMCH participants fully participated in carrying out the assessment.

4. Conclusions

In concluding, note that the Health Promotion Unit has recorded remarkable improvements in its capacity to plan, implement, and manage BCC interventions. The overall capacity index of 53.6 percent has gone up to 59.14 percent during the 2014 assessment. This increase follows action taken on the basis of the baseline assessment results, which was conducted in 2012 when the unit

was still housed in MOH. Partners, including CSH, have implemented a series of capacity-building activities, ranging from BCC trainings to the strengthening of the BCC Technical Working Groups both at the central and the provincial levels to the development of BCC guidelines to trainings in formative research and M&E.

However, note also that the realignment of the Health Promotion Unit from the MOH to MCDMCH hampered the implementation of some capacity-building efforts, for the Health Promotion Unit staff needed quite some time to fit and stabilise within MCDMCH; during this time, unit staff did not undertake BCC activities or partner support activities. It is believed that without the interruption caused by realignment issues, the unit would have recorded even better capacity to plan, implement, and manage BCC interventions. All in all, the Health Promotion Unit team demonstrated increased confidence in the unit's ability to undertake effective and evidence-based BCC interventions planning, implementation, and coordination. The major challenge remains the unavailability of the M&E system for BCC interventions within MCDMCH.

5. **Recommendations**

As a result of assessment findings, CSH has developed a list of recommendations for the Health Promotion Unit of MCDMCH. These recommendations outline specific steps of action that CSH believes will help to improve the unit's capacity to design, implement, and monitor and evaluate its BCC programmes and interventions. The recommendations are as follows:

1. MCDMCH has guidelines for the development of communication materials and messages. However, a need exists to build the capacity of MCDMCH provincial structures to enforce these guidelines at provincial levels in the development and review of materials/messages by provincial staff.
2. MCDMCH overrelies on secondary data for its planning and implementation of BCC interventions. MCDMCH needs to allocate or seek resources for formative research in order to bridge information gaps and inform the development of effective and evidence-based BCC programmes and interventions.
3. Some of the staff in the Health Promotion Unit received training in BCC. However, arising from the realignment of ministries that the new Government undertook in 2012 and the subsequent movement of staff, the competencies of staff need to be sustained and strengthened over time by having them undertake in-service trainings, such as training in M&E for BCC interventions and refresher BCC training.
4. The unit should revise checklists and other materials needed to control the quality of programme implementation, and conduct supervisory visits to observe the implementation of BCC interventions on an as-needed basis.
5. Further, MCDMCH should strengthen coordination mechanisms for stakeholders in health communication. One way to do this would be to hold regular stakeholder review meetings that serve primarily to plan and coordinate BCC intervention implementation.
6. There is a strong need for capacity building in M&E for BCC. Specifically, capacity-building efforts should focus on how to develop M&E plans for specific BCC programmes and how to effectively share and use data for programme management and improvement. MCDMCH has no M&E system for health promotion activities. HMIS does not capture information on BCC intervention. It is recommended that the Health

Promotion Unit continues with efforts aimed at integrating BCC indicators into HMIS going forward.

6. Way Forward

Based on the recommendations put forth from the assessment, CSH proposes to take a number of steps to support MCDMCH in implementing these recommendations. These steps include:

1. Provide refresher training opportunities for MCDMCH staff in BCC design, formative research, and M&E of BCC programmes;
2. Assist MCDMCH in conducting regular field supervisory visits to provincial staff in the implementation of BCC campaigns; and
3. Continue to urge and support the Health Promotion Unit's advocacy efforts aimed at integrating BCC indicators into HMIS.

As an immediate next step, CSH suggests that the Health Promotion Unit at MCDMCH, together with CSH, develop and agree upon an action plan and timeline that outlines all of the steps that both partners will need to take to implement each of the recommendations, particularly in strengthening the M&E as well as the supervisory of BCC activities.

Annex 1: Capacity Assessment Programme Agenda

Date: 7 February 2014

Venue: MCDMCH Boardroom

MCDMCH BCC Capacity Assessment Index

Agenda

Time	Activity	Facilitator
14:00 – 14:05	Arrival of Participants	All
14:05 – 14:15	• Welcome Remarks	Mr. Collins Muntanga
14:15 – 14:30	• Review of Meeting Objectives • Introduction to Capacity Assessment	Mr. Collins Muntanga
14:30 – 15:20	• Part 1 of Capacity Assessment: Planning and Design of BCC Interventions	Mr. Collins Muntanga
15:20 – 16:10	• Part 2 of Capacity Assessment: BCC Programme Implementation	Mr. Collins Muntanga
16:10 – 17:00	• Part 3 of Capacity Assessment: Monitoring and Evaluation of BCC Intervention	Mr. Victor Peleka
17:00 –17:05	• Closing Remarks • Way Forward • Tea and Snacks	Mr. Collins Muntanga All

Annex 2: Participants of the Capacity Assessment Index

#	Name	Designation
1	Mrs. Rose Masilani	Senior Health Promotion Officer
2	Ms. Beatrice Mwape	Health Promotion Officer
3	Mr. Patrick Kamangala	Graphics Officer
4	Ms. Josephine Nyambe	BCC Advisor/MCDMCH imbedded staff

Capacity Assessment Index Facilitators

#	Name	Designation
1	Mr. Collins Muntanga	M&E Advisor
2	Mr. Victor Peleka	M&E Specialist